Improve Frail Elder Care with Expert Clinical Training
GIVE YOUR CARE TEAM SKILLS TO HELP DECREASE READMISSIONS

Frail and elderly patients have complex needs and the healthcare team must develop the competencies and cooperation to properly care for them. Some of Duke University’s most respected clinicians and researchers developed an integrated program that identifies the risks and special needs of the frail and elderly patients and provides the knowledge and best practices for caring for these medically fragile patients and their families. This program—specially designed for healthcare professionals in the areas of Acute Care, Post-Acute and Longer Term Care, Home Care, and Ambulatory Care—focuses on critical areas of care such as delirium, transitions of care, medication management, malnutrition, and shared decision making.

Employee Confidence
• Increases confidence of all care team members with respect to frail elder care

Improved Communication
• Increases collaboration across the continuum of care, ACOs, and networks of providers
• Encourages consistent communication among caregivers

According to the Administration on Aging-U.S. Department of Health and Human Services, our older population—persons 65 years or older—numbered 44.7 million in 2013. They represented 14.1% of the U.S. population or about one in every seven Americans. By 2040, they are expected to represent nearly 22% of the American population and by 2060, there will be about 98 million older persons, more than twice their number in 2013.
FEATURES:

Delirium
- Reduce the chances an adult will develop delirium
- Manage care and identify behaviors that may indicate delirium

Medication Management
- Record and report accurate prescription and nonprescription medication use
- Recognize barriers to adherence with prescribed medications

Transitions of Care
- Define care transitions and their importance in optimizing patient care outcomes
- Identify characteristics that make older adults especially vulnerable during transitions
- Discuss the critical role that each interprofessional team member plays in care transitions
- Apply the National Transitions of Care Coalition (NTOCC) 7 essential interventions to ensure high quality care

Nutrition
- Identify and assess risk factors relevant for poor nutrition
- Use diagnostic aids to confirm poor nutrition
- Assess the effectiveness of the current nutritional plan
- Facilitate communication of the nutrition care plan across care settings

Shared Decision-Making
- Patient advocating
- Facilitate difficult conversations with respect to autonomous living and end-of-life care
- Understand and promote collaborative decision making

INITIATIVES AND GOALS SUPPORTED:

- Address the needs of the medically complex elderly population
- Decrease readmissions of frail elders
- Increase collaboration across the continuum of care, ACOs, and other networks of providers
- Improve CAHPS scores by fostering interprofessional care
- Promote best practices during transitions of care between healthcare entities

RECOMMENDED FOR:

- Provider/Prescribers: MD, NP, CNS, PA, PharmD
- Frontline Staff: RN, LPN, CNA
- Allied Health: PT, PTA, OT, COTA, SLP, SW, Recreational
- Therapist, Respiratory Therapists

SUBJECT MATTER EXPERTS:

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Loretta Matters, MSN, RN Director, Duke NICHE
Cindy Luddy, Operations Coordinator

CONTINUING EDUCATION CREDIT:

In support of improving patient care, Duke University Health System Clinical Education & Professional Development is accredited by the American Nurses Credentialing Center (ANCC), the Accreditation Council for Pharmacy Education (ACPE), and the Accreditation Council for Continuing Medical Education (ACCME), to provide continuing education for the healthcare team.